

**Summary of the Statement of Merrill Matthews, Ph.D.
Director, Council for Affordable Health Insurance**

**Testimony Before the
Committee on Energy and Commerce
U.S. House of Representatives
Thursday, September 8, 2005**

Welfare Reform as a Model for Medicaid Reform. What the U.S. needs today is a Tommy Thompson for Medicaid. There are surely several governors who could fill that role, if the federal government gives them the opportunity.

What We Can Learn from Welfare Reform. Welfare reform did not emerge in a vacuum. Like Medicaid today, states were seeing their welfare rolls and budgets grow. As states moved forward with welfare reform, several principles emerged. Some of these principles can and should be applied to Medicaid reform.

- (1) Provide enough flexibility to match the program to the population.
- (2) Benefits should mirror the private sector as much as possible to ease the transition.
- (3) Reward good behavior.

Can the States Do a Good Job Reforming Medicaid? I believe the states, led by the governors, can be successful with welfare reform again — this time with Medicaid.

Conclusion. The Medicaid program is 40 years old. It has helped millions of Americans get the health care they needed but couldn't afford. But it is too monolithic and rigid to adapt to changes such as consumer-driven care and increased plan flexibility that are transforming employer coverage and the insurance industry. Congress has the power to change that, and it should.

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Good morning Mr. Chairman and members of the Committee. I am pleased to be here, and I want to thank the Chairman and the Committee for calling this very important hearing today on “Medicaid: Empowering Beneficiaries on the Road to Reform.”

I am Merrill Matthews, Ph.D., director of the Council for Affordable Health Insurance (CAHI), which is located in Alexandria, Virginia. CAHI is a research and advocacy association of insurance carriers active in the individual, small group, Health Savings Account and senior markets. CAHI’s membership includes health insurance companies, small businesses, physicians, actuaries and insurance brokers. Since 1992, CAHI has been an advocate for market-oriented solutions to the problems in America’s health care system.

Mr. Chairman, the Medicaid program is growing at unsustainable rates, and has been for more than a decade. The country needs leadership both at the state and federal levels to find a way to transform the program so that it can continue to be the safety net the country wants and needs, provide quality care in a timely fashion and yet remain affordable. I commend you for your leadership in beginning this dialogue at the federal level. However, comments today focus on the need for state leadership, and for creating an environment of flexibility that will allow the states to take on that leadership role.

Welfare Reform as a Model for Medicaid Reform. What the U.S. needs today is a Tommy Thompson for Medicaid. There are surely several governors who could fill that role, if the federal government gives them the opportunity.

When Tommy Thompson was governor of Wisconsin, he experimented with welfare reform for a decade. While his actions were initially criticized by people

concerned that he would hurt the poor, his efforts to move the welfare population into productive jobs proved to be so successful that states around the country followed and built on his lead. And in 1996, Congress passed and President Clinton signed a federal version of welfare reform that incorporated Gov. Thompson's principles and experience.

Welfare reform has been one of the more successful legislative efforts undertaken by Congress and state governments; and it is important to note that governors, both Democrats and Republicans, were leading the reform efforts. They were the ones experimenting with welfare to find out what worked. Ideology wasn't driving their efforts; pragmatism was. They wanted a well-functioning welfare system that provided help to those who needed it most, but also helped the able-bodied find a job. *Welfare needed to be a safety net, not a hammock.*

Now the governors are calling for more flexibility in restructuring Medicaid. Some may only want to tweak the program; others may want more significant reforms. But we won't know what works best until Congress gives them the flexibility they need.

What We Can Learn from Welfare Reform. Welfare reform did not emerge in a vacuum. Like Medicaid today, states were seeing their welfare rolls and budgets grow. And there was a widespread perception that while some people needed and depended on their welfare benefits, others had the ability to hold down a job and move off the rolls.

As states moved forward with welfare reform, several principles emerged. Some of these principles can and should be applied to Medicaid reform.

(1) Provide enough flexibility to match the program to the population.

Populations can differ significantly from state to state. Some have higher education levels than others. Some have a good manufacturing base while others have a stronger agricultural or service-sector presence. Some have significant immigrant populations while others don't. States are more able than the federal government to know their populations and assess their needs.

In addition, the Medicaid population differs significantly. Medicaid is really three distinct programs rolled into one.

- There are seniors who rely on Medicaid for long term care coverage;

- Millions of low-income, working-age families use Medicaid as their basic insurance coverage; and,
- There are the disabled, often with chronic illnesses, who can't work.

One of the benefits of federal programs is that they tend to provide uniformity and continuity. However, federal programs can also hamper efforts to take into consideration unique needs. Reforms that work well for one of these populations may not work for the others. Increased flexibility allows the states to assess their populations and their health care providers and devise a plan that maximizes their resources.

(2) Benefits should mirror the private sector as much as possible to ease the transition. The goal of welfare reform was to move people from welfare to work. In order to facilitate that transformation, it became very important to get welfare recipients into the work environment.

We should not forget that Medicaid is a welfare program. The goal should not be to enroll more people in Medicaid, but to help those who need health care coverage now while smoothing the transition from Medicaid to private sector coverage for those who can take that step.

However, one of the problems we face in Medicaid reform is sticker shock. Once a person moves from Medicaid to employer-provided coverage, they may find their co-pays are significantly more than they were under Medicaid (e.g., increasing from \$3 to \$10 or \$15). And they may be required to pay part of their premium, either for themselves or their families.

No one wants to impose significant cost sharing on the poorest and most vulnerable Medicaid populations. But different states have different eligibility requirements for Medicaid. Some states are more generous than others. And some Medicaid beneficiaries have more means than others. To address these variations, states should have the ability to adjust co-pays and other out-of-pocket expenses by requiring more from some than they do others.

Such a policy would have two benefits.

- It would help prepare some of the Medicaid population for the day they move to an employer who offers health insurance coverage.
- Second, it would make more money available for the poorest recipients.

States might also want to consider creating new options for working families using Medicaid as an insurance policy. State welfare departments try to help beneficiaries transition to work. One way to do that is to let Medicaid coverage look more like private coverage or an employer's policy. States may want to use Medicaid funds to help employers hiring people on or coming off welfare. Or they may want to provide subsidies so that Medicaid beneficiaries can buy their own policies. Or they may want to allow them into the state employees' plan. There are several possibilities, but we simply don't know which – if any – of these options work.

Make no mistake, this policy recommendation isn't about "cutting" benefits; it's about maximizing benefits with the limited funds that are available. This recommendation simply recognizes that there should be a sliding scale in Medicaid as there is in most means-tested programs. And states should have the flexibility to set that scale.

(3) Reward good behavior. My third and final principle has to do with rewarding good behavior. Economic incentives matter. The policy problem created by Medicaid — and, indeed, any type of third-party coverage — is that it mitigates bad decisions. If Medicaid recipients live unhealthy lifestyles — being obese, for example — the Medicaid program insulates them from some of the adverse economic impact. They may see the doctor more, but they don't necessarily bear a greater financial burden.

Notice that this is not how other insurance, such as auto insurance, works. If you have a bad driving record, you pay higher premiums. Those higher premiums encourage better driving habits.

Medicaid, by contrast, often sends the wrong economic message. Take long term care, for example. We know that there is a cottage industry of elder care attorneys who help middle- and upper-middle-income families find ways to hide their assets in order to qualify for Medicaid long term care coverage in nursing homes. Medicaid should be for

the poor, but many non-poor families are able to access the program for nursing home care, imposing a huge financial strain on the states.

Several states want to try to change these incentives by providing tax breaks for the purchase of long term care insurance, being more aggressive in their estate recovery efforts or by creating long term care partnership programs that create a safe harbor for those who have bought private long term care insurance but exhaust their benefits.

Which one of these approaches would work best? I don't know. That is where the laboratory of the states comes in. They should have the freedom to experiment and find the best incentives that balance long term care coverage for those who need it while encouraging those with means to take responsibility for their future health care needs.

Of course, not all health care problems are self-inflicted, but some are. One of the newest private-sector trends is that insurers and employers are looking for ways to adjust their health insurance plans to encourage good behavior by rewarding it. They can do that because they have the flexibility to do so. States might try to do the same thing, but their hands are often tied.

Can the States Do a Good Job Reforming Medicaid? I expect there is concern about whether the states have the ability to find new and innovative solutions that get more and better care from their limited Medicaid budgets. There were similar questions raised about welfare reform.

But governors knew then that there was a lot at stake — including their jobs. They shared information, they looked at what worked and what didn't, they crafted welfare reform plans that took into consideration their populations and what could pass their legislatures. And the vast majority of them made significant progress.

I believe the states, led by the governors, can be successful with welfare reform again — this time with Medicaid. They have indicated that they want to do it, and they will be held accountable both at the state and national levels if they fail.

Conclusion. The Medicaid program is 40 years old. It has helped millions of Americans get the health care they needed but couldn't afford. But it is too monolithic and rigid to adapt to changes such as consumer-driven care and increased plan flexibility

that are transforming employer coverage and the insurance industry. Congress has the power to change that, and it should.

Mr. Chairman, we need a Tommy Thompson for Medicaid. I hope this Committee will provide the states with enough flexibility so that one can emerge.

Merrill Matthews Jr., Ph.D.

Merrill Matthews Jr., Ph.D., is director of the Council for Affordable Health Insurance in Alexandria, Virginia, and a resident scholar with the Institute for Policy Innovation. He is a public policy analyst specializing in health care issues, and is the author of numerous studies in health policy. He is past president of the Health Economics Roundtable for the National Association for Business Economics, the largest trade association of business economists, and health policy advisor for the American Legislative Exchange Council, a bipartisan association of state legislators.

Dr. Matthews served for 10 years as the medical ethicist for the University of Texas Southwestern Medical Center's Institutional Review Board for Human Experimentation, and has contributed chapters to two recently published books: *Physician Assisted Suicide: Expanding the Debate* (Routledge, 1998) and *The 21st Century Health Care Leader* (Josey-Bass, 1998).

He is a "Brain Trust" columnist for Investor's Business Daily and has been published in numerous journals and newspapers, including the Wall Street Journal, Barron's, USA Today and the Washington Times, and cited many times in Forbes. He is the political analyst for USA Radio Network and an occasional commentator for National Public Radio.

Dr. Matthews received his Ph.D. in Philosophy and Humanities from the University of Texas at Dallas.

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House Committee on Energy and Commerce

Witness Disclosure Requirement - "Truth in Testimony"

Required by House Rule XI, Clause 2(g)

Your Name: Merrill Matthews, Ph.D.		
1. Are you testifying on behalf of a Federal, State, or Local Government entity?	Yes	No X
2. Are you testifying on behalf of an entity other than a Government entity?	Yes X	No
3. Please list any federal grants or contracts (including subgrants or subcontracts) which <u>you</u> have received since October 1, 2003: None		
4. Other than yourself, please list what entity or entities you are representing: Council for Affordable Health Insurance		
5. If your answer to question number 2 is yes, please list any offices or elected positions held or briefly describe your representational capacity with the entities disclosed in question number 4: I am the director of the Council for Affordable Health Insurance		
6. If your answer to question number 2 is yes, do any of the entities disclosed in question number 4 have parent organizations, subsidiaries, or partnerships to the entities for whom you are not representing?	Yes	No X
7. If the answer to question number 2 is yes, please list any federal grants or contracts (including subgrants or subcontracts) which were received by the entities listed under question 4 since October 1, 2003, which exceed 10% of the entities revenue in the year received, including the source and amount of each grant or contract to be listed: None		

Signature: Merrill Matthews Date: Sept. 7, 2005